Exhibit 3(n): Watson

- J1094
- J1100
- J3360
- J2916
- J1580
- J1750
- J3370



REDACTED

06/04/2004 Date Issued

Amount Paid:



PEABODY, MA 01960



File Copy

This is not a Check

SHEET METAL WORKERS' NATIONAL HEALTH FUND

P.O. Box 1449

Claim No. 2538464

Goodlettsville, TN 37070-1449 Phone (615) 859-0131 Toll-free (800) 831-4914

Check No. 1082600

Explanation of Benefits

SMW+ Program



Comments:

CHARGES APPLIED TO YOUR MEDICARE PART B DEDUCTIBLE ARE NOT PAYABLE UNDER THIS PLAN. \$100.00 WAS APPLIED TO DED

ELIOT G SHERR DPM 205 ANDOVER ST PEABODY, MA 01960

Provider:

ELIOT G SHERR DPM

Participant SSN: .

RES Claim Number: 2538464



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Employee 04-3296910

> 12/01/2001 Date Issued

REDACTED

Amount Paid:

HANOVER, MA 02339

File Copy

This is not a Check

SHEET METAL WORKERS' NATIONAL HEALTH FUND

P.O. Box 1449

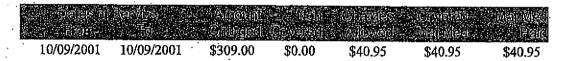
Claim No. 1618975

Goodlettsville, TN 37070-1449 Phone (615) 859-0131 Toll-free (800) 831-4914

Check No. 0142626

Explanation of Benefits

SMW+ Program



Comments:

Remodern antiferio

COMMONWEALTH HEMATOLOGY O 10 WILLARD ST **QUINCY, MA 02169**

Provider:

COMMONWEALTH HEMATOLOGY ON

Participant SSN:

DMA Claim Number: 1618975



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| IN THIS GOODLETISVILLE IN 37070 AREA | e | משומם |
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| FTT PICA HEALTH INS | URANCE CLAIM FORM PICA | ال 1 ج |
| 1. MEDICARE MEDICAID CHAMPUS CHAMPVA GROUP FECA OTHER. HEALTH PLAN BLICLUNG TREE | 11 | ╁┼┼ |
| (Medicare #) (Medicare #) (Spansor's SSN) (VA File #) (SSN or ID) (SSN) (SSN or ID) (SSN or ID) (SSN) (SSN or ID) | First (hono) Andre Indan | |
| 12 04 1935 15 | Same died of the back of the Back | |
| 5. PATIENT RELATIONSHIP TO INSURED Self [X] Speuso [Child Other] | V | |
| HAMOURED MA C ST | LINY | Ž |
| HANOVER MA Single Married Other A | ZIP CODE TELEPHONE (INCLUDE AREA CODE) | |
| 02339 Employed Full-Time Pair Time Student To | () | NECHWA |
| 10, IS PATIENT'S CONDITION RELIATED TO: | , | |
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| b. OTHER ISSURED SOLTE OF BIRTH SEAT BOOK STATE OF BOOK STAT | P. ENTERS NAME OF SOURCE INVINE TO THE SOURCE IN THE SOURC | AND INSTERED |
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| | C INSURANCE PLAN NAME OF PROGRAM NAME SHEET METAL WKRS HLTH FD | ATIERIT |
| d. INSURANCE PLAN NAME OR PROGRAM NAME 10d, RESERVED FOR LOCAL USE | d. IS THERE ANOTHER HEALTH BENEFIT PLAN? | 5 |
| MEDICARE B READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. | YES NO # yes, return to and complete item 9 a-d. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE Lauthorize | |
| 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any modical or other information occassary to process this claim. I also request payment of government benefits either to myself or to the party who apopts assignment | payment of medical benefits to the undorsigned physician or supplier to services described below. | ਸ |
| bolow. SIGNATURE ON FILE 11/09/01 SIGNED DATE | . SIGNATURE ON FILE | |
| 14. DATE OF CURRENT: \$\(\) ILLNESS (First symptom) OR \(\) 15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. | SIGNED 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION | = |
| MM OD YY WILLIAM OF REFERENCE PHYSICIAN OR OTHER SOURCE 17s. I.D. NUMBER OF REFERENCE PHYSICIAN | FROM DD YY TO MM DD YY 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES | |
| JAMES R EVERETT MD | MM DD YY MM DD YY FROM TO | ľ |
| 19, RESERVED FOR LOCAL USE | 20, DUTSIDE LAB? \$ CHARGES | \Box |
| 21. DIAGNOSIS OF NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) | YES ANO 22. MEDICAID RESUBMISSION ORIGINAL REF. NO. | \dashv |
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| INCLUDING DEGREES OR CREDENTIALS RENDERED (II other tran home or office) | COMMONWEALTH HEM-ONC | |
| apply to this bill and are made a part thereof.) | 10 WILLARD STREET | |
| JAMES EVERETT, M.D. | QUINCY MA 02169 | |
| SIGNED TI/09/01 DATE | PINF GRP# | |

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) PLEASE PRINT OR TYPE

APPROVED OMB-0338-0008 FORM HCFA-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215-0056 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)

SECOND INSURANCE

| | NATIONAL PROVIDER CHECK/EFT | HERIT. #: M2 f:12 | AGE IN! 0160 5170270 | SURANCE O | co | HPANY | 10/29/01 | | COHMONWEAL PAGE #: 3 | 125170270 TH HEMATO DF 10 | 100002167 LOGY | | MEDICARE REMITTANCE NOTICE |
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| | NAME J12474 PT RESP CLAIN INFOR | 0927 11.88 RMATIO | 092701 N FORW | 22 ARDED T | 1 0: | 99214 CLAIM- BC/BS | TOTALS OF MASS | 114,00 114.00 | 59.38 59.38 | 0.00 | 11.88 CO-86 11.88 | 54.62 54.62 | 47.50 47.50 47.50 47.50 HET |
| | JO9389 PT RESP | 1010 | 101001 | 11 | 1 | 85024 CLAIM | TOTALS | 17.00 17.00 | 11.70 11.70 | 0.00 0.00 | 0.00 CD-42 0.00 | 5.30 5.30 | 11.70 11.70 11.70 HET |
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| | NAME BOTTLE J09389 PT RESP | U.UU | | | | CLAIN | | | 3.00 3.00 | 0.00 | 0.00 CO-42 0.00 | 7.00 7.00 7.00 | 3.00 3.00 3.00 NET |
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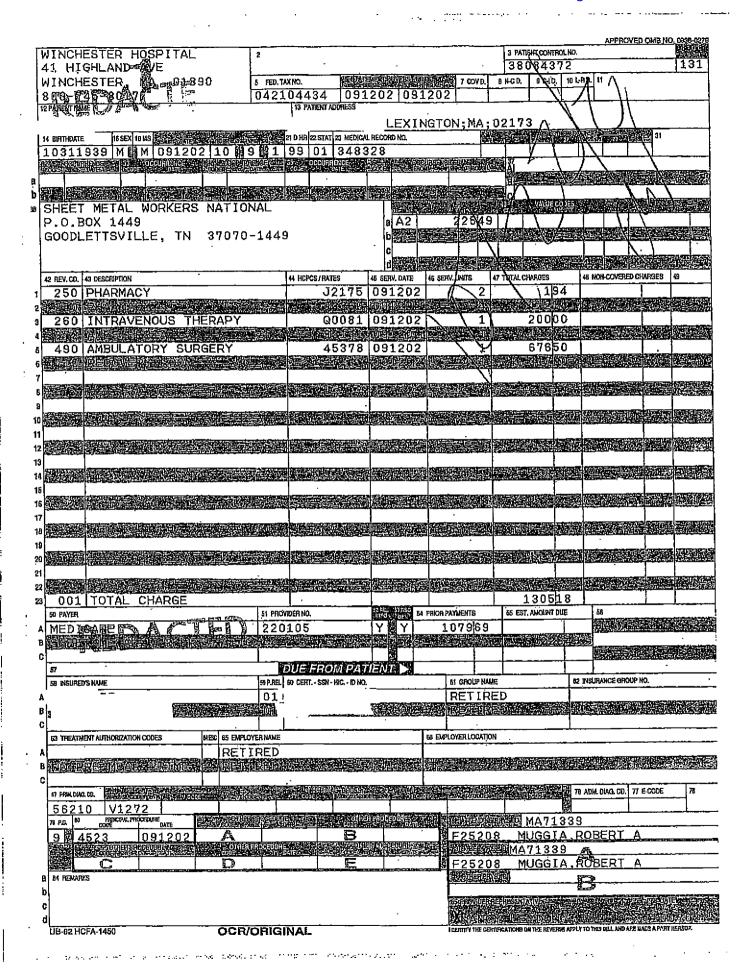
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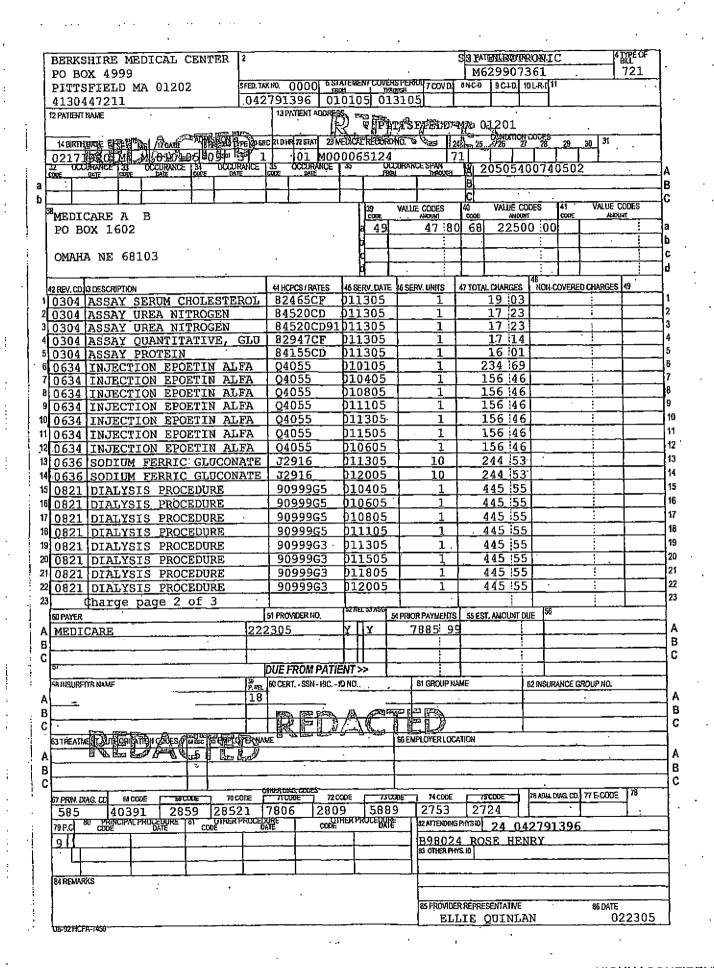




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MEDICARE INTERMEDIARY REMITTANCE ADVICE

BERKSHIRE MEDICAL CENTER

PO BOX 4999

PITTSFIELD MA 012020000

FISCAL PERIOD

ENDING

MEDICARE

MUTUAL OF OMAHA

PO BOX 2350

BILL TYPE 721

PAYMENT DATA:

OMAHA NE 681030000

INTERMEDIARY FILE DATE 04/21/05

PRINT DATE 05/12/05

PROVIDER NO. 222305

PCN M629907361

ICN 20505400740502

SERVICE FROM 01/01/05 THRU 01/31/05

PAT STAT

=DRG

.CLM STAT

CHARGES:

8406.00=REPORTED

0.00=NCVD

0.00=DENIED

5913.34≃CLAIM ADJS

8406.00=COVERED

DAYS/VISITS:

0=COST REPT

0=COVD/UTIL

0≈NON-COVERED

0=COVD VISITS

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520.01=COINSURANCE

0.00=PAT REFUND

0.00=DRG AMOUNT

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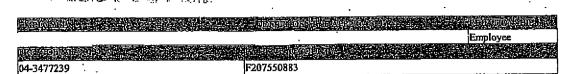
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06/22/2004 Date Issued

Amount Paid:

SO WEYMOUTH, MA 02190

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SHEET METAL WORKERS' NATIONAL HEALTH FUND

P.O. Box 1449

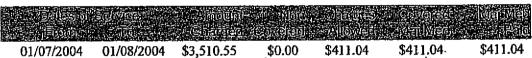
Claim No.2554958

Goodlettsville, TN 37070-1449 Phone (615) 859-0131 Toll-free (800) 831-4914

Check No. 1098039

Explanation of Benefits

SMW+ Program



01/08/2004

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\$0.00

Comments:

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QUINCY MEDICAL CENTER 114 WHITWELL STREET QUINCY, MA 02169

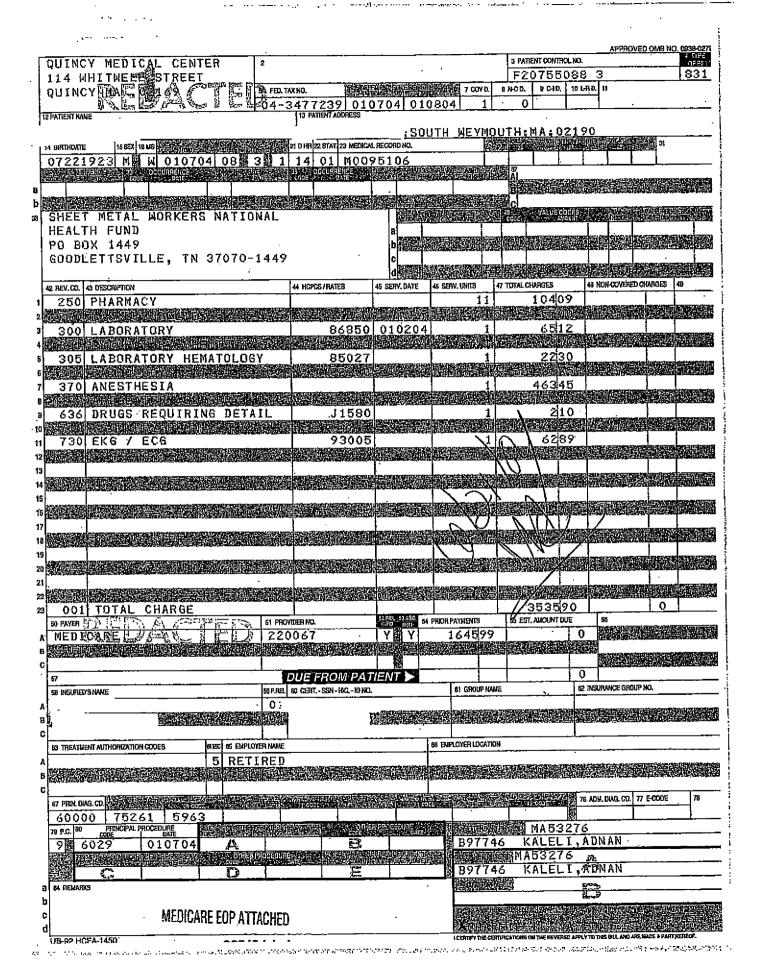
Provider:

QUINCY MEDICAL CENTER

Participant SSN: VLC Claim Number: 2554958 Dependent

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Southern Benefit Administrators, Inc. Processed by



| | CY MEDICAL CENTER 109/3 | | <u> </u> | 1 | | 20040518 PAGE 26 |
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PRODUCER: WENG MEMORIAL HOSPITAL CURP.
PARTICIPANT SSR: 014-05-3319 DEPENDENT: HOMARD : 01
SOS CLAIM NUMBER: 1915954

WILBRAHAM

MA 01095



| | | APPROVED OWN NO. 0938-0275 |
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HUTURE OF OMNIA MEDICARE 1201 FARNAM STREKT OMAHA, NEBRAGKA 68131 PROVIDER TAX LD. #:

PATIENT ACCOUNT # FINAL WORKERS' NATIONAL HEALTH FUND

PATIENT ACCOUNT # PATIENT

SHEET METAL WORKERS' NATIONAL HEALTH FUND P.O. BOX 1449 • GOODLETTSVILLE, TN 37070-1449

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SMW+ PROGRAM

SHEET METAL WORKERS' NATIONAL HEALTH FUND

P.O. Box 1449 Goodlettsville, Tennessee 37070-1449 Toll-Free 800-831-4914 Phone (615) 859-0131

EXPLANATION OF BENEFITS

| FROM DATE | TO DATE | CHARGES SUBMITTED | NON COVERED | CHARGES. ALLOWED | COVERED CHARGES | AMOUNT |
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R-COVERED CODES:

COMMENTS:

PROVIDER: WING HEMBRIAL HOSPITAL CORP.
PARTICIPART SSN: 014-03-3319 DEPEMBENT: HOWARD :01
SOS CLAIM NUMBER: 1915857

REDACTED

WILBRAHAM MA 01095

Processed by SOUTHERN BENEFIT ADMINISTRATORS, INC.

SEP = 6 2002

Medicane Summany Notice

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TERRY J RAMSEY

102 S THOMAS AVE

EVANSVILLE IN 47714-1437

Your Medicare Numbei

If you have questions, write or call:
AdminaStar Federal, Inc.
P.O. Box 6130, Indpls, IN 46206-6130
1-800-622-4792

TDD (866) 284-0881 SEND APPEALS:

P.O. Box 50410, Indpls, IN 46250-0410

VISIT US AT:

\$115 Knue Road, Indpls, IN 46250

HELP STOP FRAUD: Do not sell your Medicare number or Medicare Summary Notice.

This is a summary of claims processed from 06/25/2002 through 07/25/2002.

PART B MEDICAL INSURANCE - ASSIGNED CLAIMS

| Dates of Service Services Provided | Amount Charged | Medicare Approved | Medicare Paid Provider | You May Be Billed | See Notes Section |
|---|--------------------------------|------------------------------|------------------------------|------------------------------|-------------------------|
| Cloim number 02192910687000 EMERGENCY ROOM ASSOCIATES, PO BOX 963, EVANSVILLE, IN 47706-0963 DR. JUDE J PEREZ 06/19/02 1 Injection for nerve block (64450) 06/19/02 1 Emergency dept visit (99283-25) Claim Total | \$267.00 175.00 \$442.00 | \$57.51 56.11 \$113.62 | \$46:01 44.89 \$90.90 | \$14.50 (11.22 \$22.72 | |
| Claim number 02178941197000 SOUTHERN INDIANA IMAGING, P O BOX 138, EVANSVILLE, IN 47701-0138 Referred by: DR. DAVID W BREWER DR. JAMES D MCDANIEL 06/19/02 1 X-ray exam of finger(s) (73140-26) Professional Charge | . \$27.00 | \$6.46 | \$ 5:17 | \$1.29 | |
| Claim number 02186924488000 WELBORN CLINIC, 421 CHESTNUT ST, EVANSVILLE, IN 47713-1297 DR. GARY ERDY 06/11/02 2 Iron dextran (J1750) 06/11/02 1 Office/outpatient visit, est (99213) Claim Total | \$60.38 67.00 \$127.32 | | 37.87 | \$7.16 9.47 \$16.63 | ') |

THIS IS NOT A BILL - Keep this notice for your records.

Your Medicare Number:

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Page 2 of 3 July 25, 2002

PART B MEDICAL INSURANCE - ASSIGNED CLAIMS

(continued)

| Dates of Service | Services Provided | Amount Charged | Medicare Approved | Medicare Paid Provider | | Sec Notes ection |
|---|--|---------------------|-----------------------------|------------------------------|---------------------------|------------------------|
| WELBORN C EVANS DR. GARY EP 06/25/02 06/25/02 | -02190916434000 TLINIC, 421 CHESTNUT ST, SVILLE, IN 47713-1297 | \$67.00 \$127.32 | \$35.82 47.34 \$83.16 | \$28.66 37.87 \$66.53 | \$7.16 9.47 \$16.63 |)a |

Notes Section:

a The approved amount is based on a special payment method.

Deductible Information:

You have met the Part B deductible for 2002.

General Information:

You have the right to make a request in writing for an itemized statement which details each Medicare item or service which you have received from your physician, hospital, or any other health supplier or health professional. Please contact them directly, in writing, if you would like an itemized statement.

If you change your address, please contact the Social Security Administration by calling 1-800-772-1213.

Who pays? You pay. Report Medicare fraud by calling 1-800-447-8477. An example of fraud would be claims for Medicare items or services you did not receive. If you have any other questions about your claim, please contact the Medicare contractor telephone number shown on this notice.

SES 13 100



Medicare Summers Notice

Holladiahabbahbahbahbahbahbahbah TERRY J RAMSEY 102 S THOMAS AVE EVANSVILLE IN 47714-1437

Your Medicare Number:

If you have questions, write or call:
AdminaStar Federal, Inc.
P.O. Box 6130, Indpls, IN 46206-6130
1-800-622-4792
TDD (866) 284-0881
SEND APPEALS:
P.O. Box 50410, Indpls, IN 46250-0410
VISIT US AT:
8115 Knue Road, Indpls, IN 46250

CUSTOMER SERVICE INFORMATION

HELP STOP FRAUD: Do not sell your Medicare number or Medicare Summary Notice.

This is a summary of claims processed from 07/23/2002 through 08/22/2002.

PART B MEDICAL INSURANCE - ASSIGNED CLAIMS

| Dates of Services Provided | Amount Charged | Medicare Approved | Medicare Paid Provider | You May Be Billed | See Notes Section |
|--|------------------------------|-----------------------------|------------------------------|---------------------------|-------------------------|
| Claim number 02204923843000 WELBORN CLINIC, 421 CHESTNUT ST, | \$60.32 60.00 \$127.32 | \$35.82 47.34 \$83.16 | \$28.66 37.87 \$66.53 | \$7.16 9.47 \$16.63 | a |
| Claim number 02218922483000 WELBORN CLINIC, 421 CHESTNUT ST, EVANSVILLE, IN 47713-1297 DR. GARY ERDY 07/23/02 1 Injection, sc/im (90782) 07/23/02 2 Iron dextran (J1750) Claim Total | \$8.50 60.32 \$68.82 | \$3.51 35.82 \$39.33 | \$2.80 28.66 \$31.46 | \$0.71 (7.1% \$1.87 | a |

Notes Section:

a The approved amount is based on a special payment method.

Deductible Information:

You have met the Part B deductible for 2002.

55.73 3.1002

THIS IS NOT A BILL - Keep this notice for your records.

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COUS/ Medicare Samuery Notice

Idalladaddaladdaladdaladdaddaladd TERRY J. RAMSEY 102 S THOMAS AVE EVANSVILLE IN 47714-1437

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HELP STOP FRAUD: Read your Medicare Summary Notice carefully for accuracy of dates, services, and amounts billed to Medicare:

CUSTOMER SERVICE INFORMATION
Your Medicare Number.

If you have questions, write or call:
Medicare-AdminaStar Federal, Inc.
Inquiries- PO Box 145482, Cincinnati, OH 45250
Appeals- PO Box 812903, Chicago, IL 60681-2903
LOCATED AT:
8115 Knue Rd., Indianapolis, IN 46250

Toll Free: 1-877-602-2430 TTY/TDD 1-866-284-0881 (For the Hearing and Speech Impaired)

This is a summary of claims processed on 06/28/2002.

PART B MEDICAL INSURANCE - OUTPATIENT FACILITY CLAIMS

| COLUMN AND AVEN | | · · · · · · · · · · · · · · · · · · · | | | | | | |
|---|--|--|--------------------------------|-----------------------------------|-----------------------------------|-------------------------|--|--|
| Dates of Service | Services Provided | Amount Charged | Non- Covered Charges | Deductible and Coinsurance | You May Be Billed | See Notes Section | | |
| Control number 20217800602802 St Marys Med Ctr Of Evansvill 3700 Washington Avenue Evansville, IN 47750 Referred by: Jud J. Perez | | \$27.00 | \$0.00 | \$0.00 | \$0.00 | a b· | | |
| 06/19/02 | Pharmacy Sterile Supply X-ray exam of finger(s) (73140) Emergency dept visit (99284) Claim Total | \$37.99 4.70 91.30 440.40 \$574.39 | \$0.00 0.00 0.00 0.00 | 0.00 18.10 49.99 \$68.09 | 0.00 18:19 49.99 \$68.09 | ь) | | |

Notes Section:

- a The amount Medicare paid the provider for this claim is \$129.77.
- b Payment is included in another service received on the same day.

THIS IS NOT A BILL - Keep this notice for your records.

559 23 7802

Employee 04-2103602 25217241 1

70

Date Issued

Amount Paid:

MEDWAY, MA 02053



File Copy

This is not a Check

SHEET METAL WORKERS' NATIONAL HEALTH FUND

P.O. Box 1449

Claim No.3093339

Goodlettsville, TN 37070-1449 Phone (615) 859-0131 Toll-free (800) 831-4914

Check No. 1605648

Explanation of Benefits

SMW+ Program



Comments:

Provider:

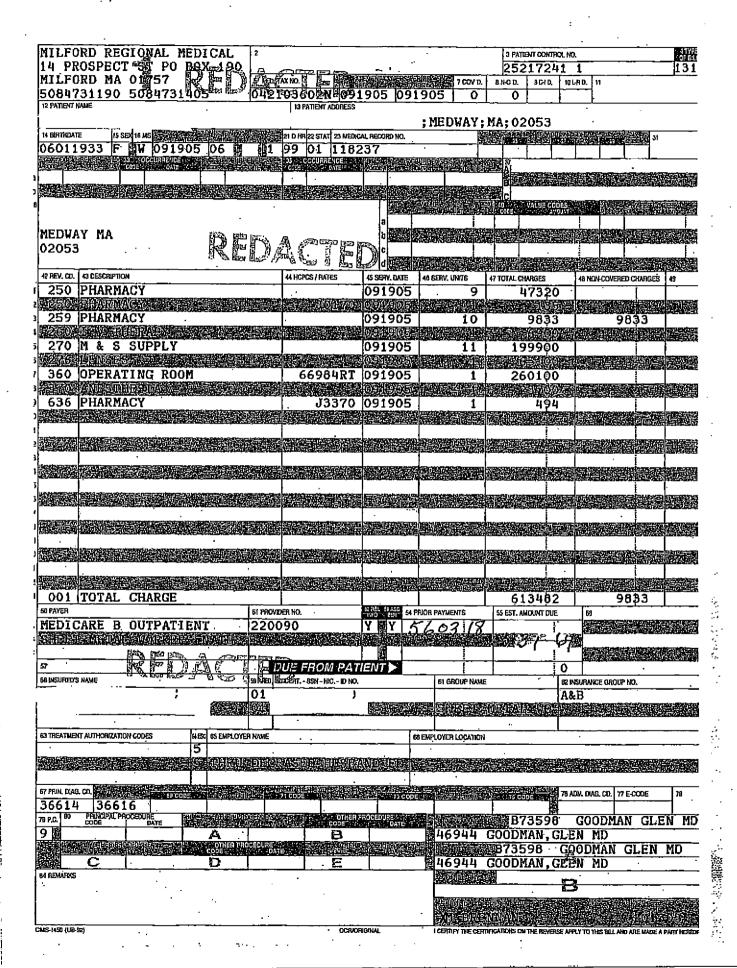
Participant SSN:

SMG Claim Number: 3093339

MILFORD REGIONAL MEDICAL CEN 14 PROSPECT ST MILFORD, MA 01757

Processed by





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| ٦ | 56 119 NAME CHG=QC | 108625 HIĆ CHG=HN TOB=131 | | 01 01 01 01 | 451.00 0.00 0.00 451.00 | 0.001 0.003 1 | 0.00 0.00 38.04 0.00 | 0.310] 0.00] 0.00] 0.00] | 72.21 45.28 340.75 0.00 | 0.00 0.00 0.31 72.21 |
| / | 57 19 NAME CHG=QC | 168020 HIC CHG=HN TOB=131 | | 0 0 0 0 | 944.00 0.00 .0.00 944.00 | 0.00[0.00] 0.00] 1 | | 0.310 0.00 0.00 0.00 | 80.37 25.69 818.90 0.00 | 0.00 0.00 0.31 80.37 |
| | 58 1 Name Chg=QC | 164905 HIC CHG=HN TOB=131 | 050919 050919 0 0 | 10 10 10 10 | 62,00 0.00 0.00 62,00 506.00 | 0.00 0.00 | 0,00 0.00 0.00 0.00 | 0.001 0.00 | 17.04[17.04] 44.96[0.00] | 0.00 0.00 0.31 17.04 |
| 0 | 59 .]1 NAME CHG=QC | 1113082 HIC CHG=HN TOB=131 | 050916 | 10 10 10 10 10 | 0.00 { 0.00 } 506.00 [| 0.00 0.00 1 | 0.00 0.00 | 0.310 0.00 0.00 0.00 | 55.14 450.86 0.00 | 0.00 0.31 55.14 |
| J | 60]1 MAME CHG=QC | 174913 HIC CHG=HN TOB=131 | 10509171 I I | 0 i - 0 i - 0 i | 0.00 0.00 3335.46 440.00 | 0.00 0.00 1 | 0.001 265.57] | 0.00 0.00 0.00 0.00 | 30.12 2592.77 0.00 | 0.00 0.31 477.12 |
| ン | 61 1 NAME CHG=QC | 195913 HIC CHG=HN TOB=131 | [050919] [| 0] 0] 0] | 0.00 0.00 410.00} | 0.00 0.00 | 0.00 0.00 | 0.00 0.00 0.00 | 57,90] 382,10] 0.00] | 0.00 0.31 57.90 |
| .) | 62 119 Name Chg=QC | 116397 HIC CHG=HN TOB=131 | 050919 | 01 01 01 | 1.54 0.00 258.00 6134.82 | 0.00 0.00 | <u>0</u> .00i | 0.001 0.001 0.001 0.001 | 0.00 175.27 0.00 | 0.00 0.31 61.75 |
| | 63 1 Symple calcolor A Color | 1118237 HIC CHG=HW TOB=231 | 050919 | 0 0 0 | 98.33 0.00 6036.49 | 0.00 0.00 1 | 0.00 531.64 0.00 | 0.00 0.00 0.00 0.310 | 0.00 4611.37 0.00 | 0.00 0.31 893.48 |
| . / | 64 11 NAME CHG-QC | 1208279 HIC CHG=HN TOB=131 | 050920 | 0 0 0 0 | 0.001 0.001 178.001 | 0.00 00.0 - | 0.00 0.00 | 0.00] 0.00] 0.00] 0.310] | 14.79 163.21 0.00 28.63 | 0.00 0.31 14.79 0.00 |
| <u>・</u> | 65 [1 NAME CHG=QC | 210302 HIC CHG=HN TOB=131 | [050919] [| 01 01 01 | 0.00 0.00 428.00 45.00 | 0.00.0 [00.0 · | 0.00 0. 00 | 0.00 0.00 0.00 0.00 | 28.63 399.37 0.00 | 0.00 0.31 28.63 |
| | 66 1 NAME CHG=QC | 140279 HIC CHG=HN TOB=131 | [050916] [| 10 10 10 | 0.00 0.00 45.00 | 0.00 0.00 | 0.00 0.00 | 0.001 0.001 0.001 | 7.16 37.84 0.00 | 0.00 0.31 7.16 |